To receive benefits from this Plan, make sure the Provider is a member of the Provider Network shown on the member ID card. If you receive services from an Out-of-Network Provider, you will be responsible for the full payment of the Out-of-Network Provider's charge.

Covered Services	Benefits for Covered Services received from Network Providers	Benefit Limits
Services Received at the Practitioner's Office		
Services for Preventive Care		
Well Woman Exam Includes: • Cervical cancer screening	100%	One Well Woman exam per Calendar Year, subject to office visit limit of six (6) visits per Calendar Year for medical, surgical or preventive services performed in an office setting
Preventive mammogram	100%	Included with one well woman visit per Calendar Year Mammograms performed in an outpatient setting will be subject to the outpatient visit limit of two (2) non-surgical visits per Calendar Year
Well Care Services Includes: • Annual health assessment • Immunizations • Preventive screenings, including non-invasive colorectal or prostate cancer (does not include flexible sigmoidoscopy or colonoscopy)	100%	One Well Care exam per Calendar Year, subject to office visit limit of six (6) visits per Calendar Year for medical, surgical or preventive services performed in an office setting
Office Services for Diagnosis and Treatment of Illness or Injury		
Office visits for diagnosis and treatment of Illness or Injury	100% after $20 copay	Subject to office visit limit of six (6) visits per Calendar Year for medical, surgical or preventive services performed in an office setting
Office Surgery, including anesthesia Colonoscopies are not covered when performed in an office setting	100% after $20 copay	Subject to office visit limit of six (6) visits per Calendar Year for medical, surgical or preventive services performed in an office setting
Non-routine treatments: Includes chemotherapy and radiation therapy	100%	Subject to office visit limit of six (6) visits per Calendar Year for medical, surgical or preventive services performed in an office setting

Routine Diagnostic Services for Illness or Injury Non-Routine Diagnostic Services are not covered when performed in the office.	100%	Office visit must be covered for related lab work and X-ray to be covered Does not count toward visit limit when performed separately from an office visit Office lab and X-ray services are not covered after the office visit limit is met
Services Received at a Facility		
Inpatient Hospital Stays Prior Authorization required. Benefits will be denied for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization. Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility Charges	100% after $100 copay per admission	Subject to $15,000 annual payment limit for inpatient medical and behavioral health services
Practitioner Charges	100%	Inpatient stay must be covered
Facility Charges related to Behavioral Health Services	100% after $100 copay per admission	Subject to $15,000 annual payment limit for inpatient medical and behavioral health services Inpatient Behavioral Health Services limited to five (5) days per Calendar Year
Practitioner Charges related to Behavioral Health Services	100%	Inpatient stay must be covered
Hospital Emergency Care Services In the event of a true Emergency, benefits are available from Network and Out-of-Network Providers.		
Facility Charges: Emergency Condition Non-emergency Condition	100% $100 copay per visit	Limited to two (2) Emergency Room visits per Calendar Year
Practitioner Charges	100% after $25 copay per encounter for both emergent and non-emergent conditions	Limited to two (2) Emergency Room visits per Calendar Year
Urgent Care Services		
Facility Charges	100% after $25 copay per visit	Limited to two (2) non-surgical outpatient visits and one (1) surgical outpatient visit per Calendar Year
Practitioner Charges	100% after $20 copay	Subject to office visit limit of six (6) visits per Calendar Year for medical, surgical or preventive services performed in an office setting

Outpatient Facility Services and Outpatient Surgery Surgeries include invasive diagnostic services (e.g. colonoscopy, sigmoidoscopy)		
Facility Charges	100% after $25 copay per visit	Subject to outpatient visit limit of one (1) surgical visit per Calendar Year
Practitioner Charges	100%	Subject to outpatient visit limit of one (1) surgical visit per Calendar Year
Preventive invasive screenings (e.g. colonoscopy, sigmoidoscopy)	100%	Subject to outpatient visit limit of one (1) surgical visit per Calendar Year

Outpatient Diagnostic Services		
Non-Routine Diagnostic Services for illness or injury: CAT scans, MRI's, PET scans, nuclear medicine and other similar technologies.	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
All other diagnostic services for illness or injury	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Preventive mammogram	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Cervical cancer screening	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Preventive non-invasive colorectal screening (does not include flexible sigmoidoscopy or colonoscopy)	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Prostate cancer screening	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Other Well Care Screenings	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Other Outpatient Procedures, Services, or Supplies		
Facility Charges related to Behavioral Health Services	100% after $25 copay per visit	Outpatient Behavioral Health Services limited to ten (10) visits per Calendar Year
Practitioner charges related to Behavioral Health Services	100%	Outpatient behavioral health services limited to ten (10) visits per Calendar Year
All Other services received at an outpatient facility, including chemotherapy and radiation therapy	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year

Other Services		
Ground Ambulance	100%	Limited to two (2) trips per Calendar Year
Home Health Care Services, including home infusion therapy. Prior Authorization is required.	100%	Subject to annual payment limit of $500
Hospice Care	100%	Subject to annual payment limit of $5,000 for inpatient and/or outpatient and/or home services

Services Received at the Pharmacy		
Prescription Drugs		
Prescription Formulary Generic Drugs Benefits for Generic Drugs are limited to the Generic Drugs listed on the CoverTN Formulary.	100% after $8 copay per 30-day supply	Subject to Calendar Quarterly payment limit of $75 (includes insulin, blood glucose monitors, blood glucose test strips and generic drugs). Unused benefits do not accumulate towards the next Calendar Quarter. Generic drugs purchased from an Out-of-Network Pharmacy are not covered.
Prescription Formulary Brand Drugs Benefits for Brand Drugs are limited to Insulin and the Diabetic Supplies listed on the CoverTN Formulary.	100% after $25 copay per 30-day supply	Subject to Calendar Quarterly payment limit of $75 (includes insulin, blood glucose monitors, blood glucose test strips and generic drugs). Unused benefits do not accumulate towards the next Calendar Quarter. Brand drugs purchased from an Out-of-Network Pharmacy are not covered.
Diabetic Supplies		
Blood Glucose Monitors	100%	Subject to Calendar Quarterly payment limit of $75 (includes insulin, blood glucose monitors, blood glucose test strips and generic drugs). Unused benefits do not accumulate towards the next Calendar Quarter.
Blood Glucose Test Strips	100% after $25 copay	Subject to Calendar Quarterly payment limit of $75 (includes insulin, blood glucose monitors, blood glucose test strips and generic drugs). Unused benefits do not accumulate towards the next Calendar Quarter.
Diabetic Supplies (needles, syringes, lancets, alcohol swabs)	100% after $5 copay	Subject to monthly payment limit of $50. Unused benefits do not accumulate towards the next month.

Miscellaneous Benefit Limits	Network Providers
Annual Plan Payment Maximum – All Covered Services	$25,000
Pre-Existing Condition Waiting Period	12 Months

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